100th CONGRESS
1st Session

COMMITTEE PRINT

WMCP: 100-19

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

REPORT

ON

OUTPATIENT PRESCRIPTION DRUGS

Explanation of Committee Amendment to H.R. 2470 Providing Medicare Coverage of Catastrophic Illness Expenses for Outpatient Prescription Drugs

JULY 24, 1987

Prepared for the Use of the Committee on Ways and Means by its staff

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U.S. GOVERNMENT PRINTING OFFICE

75-589

WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H782-37

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PREFACE

This document is an explanation of the committee amendment approved by the Committee on Way and Means on June 24, 1987, to provide Medicare coverage of catastrophic illness expenses for outpatient prescription drugs, and has been prepared in the form of a Committee Report in order to establish legislative history. The committee amendment is intended as a free-standing amendment to H.R. 2470, the Medicare Catastrophic Protection Act of 1987, previously reported by the Committee on Ways and Means on May 7, 1987. H.R. 2470, as passed by the House on July 22, 1987, is the text of H.R. 2941, the successor bill to H.R. 2470, and includes provisions passed by the Committees on Ways and Means and Energy and Commerce.

The first part of this committee print is a background and summary of the committee amendment. The second part is an explanation of the provisions of the committee amendment. The third part presents the estimated budget effects of the committee amendment. The fourth section consists of the vote of the committee, the oversight findings, the summary of findings and recommendations of the Committee on Government Operations, and an inflationary impact statement. The fifth and final part is the statutory language of the committee amendment.

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OUTPATIENT PRESCRIPTION DRUGS

I. Background and Summary

A. BACKGROUND

The Congressional Budget Office estimates that Medicare beneficiaries will spend $8.7 billion a year on outpatient prescription drugs in 1989. Outpatient prescription drugs will account for 33 percent of total acute care out-of-pocket costs.

Currently, Medicare coverage of outpatient prescription drugs is limited to one-year coverage of immunosuppressive drugs for patients with organ transplants.

Although average spending on drugs for Medicare beneficiaries will be only $268 a year in 1989, many will spend substantially more.

It is estimated that 2.6 million Medicare beneficiaries (about 8 percent) will spend more than $800 a year on outpatient prescription drugs. Average spending on drugs for this group will be $1,339 a year.

Beneficiaries with high drug costs also have high Medicare coinsurance and deductible payments. Beneficiaries with drug expenses over $800 a year will incur average Medicare coinsurance and deductible payments of $1,023 under current law and $679 under H.R. 2470 during 1989.

These statistics show that outpatient prescription drugs are a catastrophic illness expense for many Medicare beneficiaries.

The need for prescription drug coverage was first raised at a March 30, 1987, hearing held by the Subcommittee on Health on the issue of Medicare coverage for catastrophic illness expenses. A full hearing was devoted to prescription drug coverage on April 23, 1987, and June 2, 1987.

B. SUMMARY OF COMMITTEE AMENDMENT

(a) *Coverage.*—Medicare beneficiaries would be entitled to insurance coverage for outpatient prescription drugs. All federally approved prescription drugs, biological drugs, and insulin products would be covered.

(b) *Deductible.*—Benefit payments would be made after an annual deductible has been met. The deductible for 1990 would be $800. Starting in 1991, the deductible would be indexed to reflect increases in retail drug prices.

(c) *Coinsurance.*—Beneficiaries would be required to pay a 20 percent coinsurance, after the deductible has been met, based on the pharmacy's actual charge.

(d) *Payment rules.*—The payment method depends on whether the physician has prescribed a single source drug (typically a brand-name drug for which there are no generic equivalents), or a

multiple source drug (a drug for which there are two or more generic equivalents which have been approved by the Food and Drug Administration as therapeutically equivalent).

Generally, the approved charge for a single source drug would be the lower of: (i) the pharmacy's actual charge for the brand prescribed by the physician, or (ii) the average wholesale price for the brand, plus a dispensing fee. The same rule would apply for a multisource drug if the physician has indicated in the manner provided by State law that a particular brand must be dispensed. Otherwise, the approved charge for a multiple source drug would be the lower of: (i) the actual charge, or (ii) a limit set at 50 percent of the average wholesale price of the corresponding brand-name drug as of January 1, 1987, indexed forward by the medical care component of the Consumer Price Index plus a dispensing fee.

Starting in 1991, the dispensing fee would be indexed to reflect year-to-year changes in costs incurred by pharmacies in dispensing prescription drugs. Average wholesale prices would generally be determined every 6 months on a national basis.

(e) *Participation and assignment.*—Pharmacies would have the option of signing a participation agreement. A participating pharmacy would be required to accept assignment on all claims for beneficiaries who have satisfied the annual deductible. Drugs purchased at nonparticipating pharmacies would be covered by the benefit, but the beneficiary would be required to pay the pharmacy out-of-pocket and then submit a claim to Medicare for reimbursement.

(f) *Administration.*—Participating pharmacies would be required to assist beneficiaries in determining whether their expenses exceed the annual deductible and submit appropriate documentation to the Medicare carrier. Participating pharmacies would be entitled to prompt payment under provisions of the Omnibus Budget Reconciliation Act of 1986. The prompt payment standard for fiscal year 1990 would be 17 calendar days.

(g) *Miscellaneous provisions.*—A Prescription Drug Payment Advisory Commission would be established to advise Congress on payment of prescription drugs under Medicare. The 11-member Commission would be appointed by the Director of the Office of Technology Assessment. The Secretary would be required to conduct a survey concerning prescription drug spending by the elderly, to be completed by December 31, 1988. The Secretary would also be required to develop a comparative drug-price information guide to be distributed to physicians and hospitals annually beginning in 1989. The guide would provide cost comparisons for medications used for the treatment of common medical conditions.

(h) *Financing.*—The benefit would be fully financed by premiums. General revenues would not be used. Three quarters of the cost would be financed by an increase in the "flat" monthly Medicare Part B premium, while the remainder would be financed by an increase in the supplemental premium provided under H.R. 2470. The flat premium and the supplemental premium would be increased, as necessary, on a year-to-year basis, to cover increases in program costs. Premiums would be adjusted to take into account surpluses or deficits in preceding years to assure budget neutrality.

(i) *Expenditure cap.*—A cap would be set for outlays for drugs in calendar year (CY) 1991. The cap for CY 1991 would be $1 billion above the Congressional Budget Office outlay estimate for the year. The Secretary would be required to report to Congress by May 1, 1992, if actual outlays for drugs during CY 1991 exceed the CY 1991 target. As part of the report, the Secretary would be required to recommend changes in policies (including an increase in the annual deductible) sufficient to reduce projected CY 1993 expenditures by the amount by which CY 1991 expenditures exceeded the CY 1991 target, increased by an inflation factor.

(j) *Effective date.*—The drug benefit would be effective for prescriptions filled on, or after, January 1, 1990. The increase in the Medicare Part B monthly premium would be effective on January 1, 1990. The Medicare supplemental premium would be effective for tax years beginning, on or after, January 1, 1990.

II. Explanation of Committee Amendment

Current Law

Outpatient prescription drugs are not covered as a benefit under Medicare Part B except for immunosuppressive drugs which are covered for up to 1 year in patients with organ transplants.

The Part B premium, which is currently $17.90 a month, is set at 25 percent of total Part B program costs. Beginning in 1989, the Part B premium for a year will be set at the previous year premium amount increased by the percentage by which cash benefits were increased under the Social Security cost-of-living adjustment (COLA).

Committee Bill

H.R. 2470 would provide acute care catastrophic protection for hospital and physician services. The bill does not provide for coverage of outpatient prescription drug costs resulting from catastrophic illness.

The cost of acute care catastrophic coverage under H.R. 2470 would be financed by an increase in the monthly ("flat") Medicare Part B premium and by a new income-related supplemental premium. The flat monthly premium would be increased by $1 in 1990, $1.50 in 1991, and $1.50 in 1992. Thereafter, the additional premium would be indexed to the cost of living.

Individuals entitled to receive benefits under Medicare Part A would be required to pay a supplemental premium depending on adjusted gross income ("AGI"), and collected through the income tax. The supplemental premium would be determined according to a table on the tax form. In 1988, single returns with AGI of less than $6,000 and joint returns with AGI of less than $12,000 would have no supplemental premium liability. The maximum supplemental premium would be $580 per enrollee in 1988.

The AGI bracket amounts in the table would be indexed according to the cost of living in the same manner as income tax brackets. The supplemental premium for each bracket would be increased according to the cost of the Medicare program.

Proposal

(a) *Prescription drug benefit coverage.*—Medicare beneficiaries would be entitled to insurance coverage for outpatient prescription drugs and insulin. All federally approved prescription drugs, biological drug products, and insulin products would be covered.

(b) *Deductible.*—For benefit payments to be made, a Medicare beneficiary must incur expenses for covered outpatient drugs that exceed an annual deductible amount. For calendar year 1990, the annual deductible would be $800.

Starting in 1991, the deductible would be indexed by an index, established by the Secretary ("the Secretary") of Health and Human Services, which reflects year-to-year increases in prescription drug prices at the retail level.

In the case of drugs provided free-of-charge under a drug benefit plan offered by a health maintenance organization (HMO) to its enrollees, the pharmacy's standard charge to customers not covered by the plan would be used to determine expenditures.

(c) *Coinsurance.*—Beneficiaries would be required to pay coinsurance of 20 percent, based on the pharmacy's actual charge.

(d) *Payment rules.*—The payment method depends on whether a single source or a multiple source drug has been prescribed. A single source drug is a drug (typically a brand-name drug) for which there are no generic equivalents. A multiple source drug is a drug for which there are two or more generic equivalents which have been approved by the Food and Drug Administration (FDA) as therapeutically equivalent.

Generally, the approved charge for a single source drug would be the lower of: (i) the pharmacy's actual charge for the brand prescribed by the physician, or (ii) the average wholesale price for the brand prescribed by the physician, plus a dispensing fee. The same rule would apply for a multiple source drug if the physician has indicated in the manner provided by State law that a particular brand must be dispensed. Otherwise, the approved charge for a multiple source drug would be the lower of: (i) actual charge, or (ii) a limit set at 50 percent of the average wholesale price of the corresponding brand-name drug as of January 1, 1987, indexed forward by the medical care component of the Consumer Price Index plus a dispensing fee.

The beneficiary's coinsurance payment would be subtracted from the Medicare approved charge to determine the Medicare payment amount.

The dispensing fee is intended to cover the salary of the dispensing pharmacist and associated overhead costs. During calendar year 1990, the dispensing fee would be set at $4.50 per prescription. Starting in 1991, the dispensing fee would be indexed, by an index established by the Secretary, which reflects year-to-year changes in costs incurred by pharmacies in dispensing prescription drugs. The index would also include an adjustment for changes in productivity.

The average wholesale price would generally be determined every 6 months on a national basis. However, the Secretary would be authorized to determine the average wholesale price on a regional basis, if necessary, to take into account limitations on the

availability of drug products or variations in wholesale prices in different regions.

(e) *Participation and assignment.*—Pharmacies would have the option of signing a participation agreement. A participating pharmacy would be required to accept assignment on all claims for beneficiaries who have satisfied the annual deductible.

Drugs purchased at nonparticipating pharmacies would be covered by the benefit, but the beneficiary would be required to pay the pharmacy out-of-pocket and then submit a claim to Medicare for reimbursement.

To qualify for participation, pharmacies must be licensed under State law. Participating pharmacies would be required to:

(i) Agree not to discriminate against Medicare beneficiaries in the sale of retail drugs;

(ii) Not charge beneficiaries more than the general public;

(iii) Maintain patient records, including records on expenses incurred by beneficiaries;

(iv) Provide advice concerning appropriate drug use and the availability of generic equivalents;

(v) Submit all claims electronically effective January 1, 1991, except that this requirement would not apply to pharmacies located in rural areas.

Pharmacies operated by HMOs for the benefit of HMO members would not be required to sell drugs to Medicare beneficiaries not enrolled in the HMO.

(f) *Administration.*—Participating pharmacies would be required to assist beneficiaries in determining whether their expenses exceed the annual deductible. If a pharmacy believes that the deductible has been satisfied, it would, upon the request of the beneficiary, submit appropriate documentation (including a list of drugs purchased with date of purchase and price) to the Medicare carrier.

The carrier, in turn, would review the information submitted by the pharmacy to determine whether the deductible has been met. Pharmacies could exchange information on expenditures to deal with the problem of documenting expenditures in the case of beneficiaries who purchase drugs at more than one pharmacy. Claims for payment would be submitted by pharmacies only after the carrier has determined that the deductible has been met.

Pharmacies would be subject to a periodic audit to protect against overcharging and fraudulent claims. Payment would be limited to a 60-day supply of medications for each prescription.

Participating pharmacies would be entitled to prompt payment under provisions of the Omnibus Budget Reconciliation Act of 1986. The prompt payment standard for fiscal year 1990 would be 17 calendar days.

The Secretary would be required to establish a utilization review program to identify and prevent inappropriate prescribing or dispensing practices and to monitor quality of care.

The Secretary would be authorized to use regional carriers in administration of the drug benefit.

The Secretary would be required to adjust the adjusted average per capita cost under section 1876(a) of the Social Security Act for health maintenance organizations and competitive medical plans to take into account the cost of benefits added by this provision.

(g) *Miscellaneous provisions.*--A Prescription Drug Payment Advisory Commission would be established to provide independent technical advice to Congress concerning payment of outpatient prescription drugs under Medicare. There would be 11 members on the Commission. Members would be appointed by the Director of the Office of Technology Assessment. The Director would be required to select Commissioners who are recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement. At least one would be a Medicare beneficiary.

The Commission would review current methods for paying for prescription drugs under Medicare and make recommendations for change. The Commission would report its recommendations to Congress annually by no later than March 1 of each year. The Commission would be authorized to appoint staff and to operate under provisions similar to those provided under current law for the Prospective Payment Assessment Commission. There would be an authorization for an appropriation from the Supplementary Medical Insurance Trust Fund for sums necessary to carry out the responsibilities of the Commission.

The Secretary would be required to conduct a survey of prescription drug expenses incurred by Medicare beneficiaries. The Secretary would be required to consult with the General Accounting Office and the Congressional Budget Office (CBO) in developing the study design. The purpose of the survey would be to determine the distribution of drug spending by dollar level for the Medicare population and would categorize drug spending by a variety of factors such as age, sex, and institutionalization. The Secretary would be required to submit the survey results to CBO and to Congress no later than December 31, 1988. CBO would be required to develop an estimate of prescription drug benefit costs under Medicare to be submitted to Congress by no later than 4 months after the due date of the survey.

The Secretary would be required to conduct a study of issues related to coverage of drugs under Medicare. The study would address the following issues: the extent of private or other third-party insurance coverage for prescription drugs among Medicare beneficiaries; a comparison of published average wholesale price and actual pharmacy acquisition costs by type of pharmacy (independent, chain, hospital); overhead costs of retail pharmacies; potential application of new claims processing and billing technologies; utilization review methods; alternative payment methodologies to promote greater program efficiency, including the use of lower cost medications; and the potential for induced demand resulting from prescription drug coverage. As part of the study, the Secretary would be required to conduct a longitudinal study of outpatient prescription drug use by Medicare beneficiaries with analysis of medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage. The study would be submitted in a series of reports to Congress. The overall completion date would be January 1, 1990.

The Secretary would be required to develop an information guide for physicians concerning comparative costs of medications that

have been approved for the treatment of common medical conditions. The guide should contain information concerning no less than 500 drugs. Cost comparisons would be based on the average wholesale prices. To the extent practicable, the comparisons would group drugs commonly used for the treatment of particular medical conditions and would compare the typical daily cost of similar therapeutic regimens. The information guide would be updated on an annual basis. A copy of the guide would be sent by no later than March 1 of each year to all physicians providing services on a routine basis to Medicare beneficiaries and to all hospitals.

The reimbursement method for immunosuppressive drugs would be changed to conform with general payment rules for outpatient prescription medications. Currently, reimbursement for these drugs is on the basis of customary and prevailing charges. Under the conforming amendment, payment would be on the basis of the lower of actual charges or average wholesale price plus the standard dispensing fee.

(h) *Financing.*—Three quarters of the total administrative and benefit cost of the outpatient prescription drug benefit would be financed by an increase in the monthly Medicare Part B premium. The remaining quarter would be financed by an increase in the supplemental premium under H.R. 2470.

Starting on January 1, 1990, the monthly Part B premium would be increased by $1.40. This amount is estimated to raise premium revenues sufficient to cover 75 percent of the CBO estimate of total program outlays related to the drug benefit for 1990.

In 1991 and subsequent years, the additional premium related to drug coverage would be determined on the basis of a monthly actuarial rate determined by the Secretary of Health and Human Services. The monthly actuarial rate would be set at an amount which would produce aggregate premium revenues in a year sufficient to cover 75 percent of estimated program outlays during the year. In setting the monthly actuarial rate, the Secretary would take into account surpluses or deficits during preceding years to assure budget neutrality.

The Medicare supplemental premium provided under H.R. 2470 would be increased on a percentage basis by a prescription drug factor. For tax year 1990, the prescription drug factor would be 3.5 percent. This will raise revenues during tax year 1990 sufficient to cover the 25 percent of the total program outlays estimated by CBO for 1990.

For tax years beginning in 1991 and subsequently, the prescription drug factor would be set at a rate which the Secretary of the Treasury estimates to be necessary so that the total amount of revenues generated is equal to 25 percent of estimated total program outlays for the calendar year. The prescription drug factor would be adjusted to account for any surpluses or deficits in preceding years to ensure budget neutrality.

Premiums for Medicare Part B only beneficiaries and residents of Puerto Rico and the territories would be determined in a manner similar to that provided under H.R. 2470.

(i) *Expenditure cap.*—A cap would be set for outlays for drugs in calendar year 1991. The cap for CY 1991 would be $2.22 billion which is $1 billion above the CBO outlay estimate for the year. The

Secretary would be required to report to Congress by May 1, 1992, concerning outlays for drugs in CY 1991. If actual outlays for drugs during CY 1991 exceeds the CY 1991 cap, the Secretary would be required to make a report to Congress. The Secretary could report to Congress at any time prior to May 1, 1992, if actual outlay data indicates that program costs are running at an amount in excess of the cap.

In the report, the Secretary would be required to recommend changes in policies (including an increase in the annual deductible) sufficient to reduce projected CY 1992 expenditures by the amount by which CY 1991 expenditures exceeded the CY 1991 target, increased by the projected percentage increase the estimated program cost per enrollee from CY 1991 to CY 1993.

Effective Date

The drug benefit would be effective for prescriptions filled on or after January 1, 1990. The increase in the Medicare Part B monthly premium would be effective on January 1, 1990. The Medicare supplemental premium would be effective for tax years beginning on or after January 1, 1990.

III. Budget Effects of Committee Amendment and Vote of the Committee

A. BUDGET EFFECTS

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the following statement is made: the committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, the committee states that the letter from the Congressional Budget Office indicates that there is a change in budget authority and that there is no new or increased tax expenditures as a result of this amendment.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 15, 1987.

Hon. Dan Rostenkowski,
Chairman, Committee on Ways and Means,
U.S. House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for amendments to H.R. 2470, Relating to Coverage of Outpatient Prescription Drugs Under Medi-

care, as ordered reported by the House Committee on Ways and Means on June 24, 1987.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: Amendments to H.R. 2470.

2. Bill title: Relating to coverage of outpatient prescription drugs under Medicare.

3. Bill status: As ordered reported by the Committee on Ways and Means on June 24, 1987.

4. Bill purpose: To amend title XVIII of the Social Security Act to provide catastrophic prescription drug and insulin expenses under the Medicare Program.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Covering catastrophic expenses for prescription drugs:					
Budget authority	0	0	485	1,115	1,440
Outlays	0	0	485	1,115	1,440
Increasing part B premium to cover resulting outlay costs:					
Budget authority	0	0	−420	−915	−1,165
Outlays	0	0	−420	−915	−1,165
Effects of Medicare provision on Federal Medicaid costs:					
Budget authority	0	0	−20	−45	−60
Outlays	0	0	−20	−45	−60
Total direct spending/offsetting receipts:					
Budget authority	0	0	45	155	215
Outlays	0	0	45	155	215
Amounts subject to appropriations: Administrative costs for drug benefit:					
Outlays, total	0	95	105	105	110
Revenues: Imposing an income-related supplemental premium [1]: Revenues	0	0	67	285	440
Total:					
Budget authority	0	0	45	155	215
Outlays	0	95	150	260	325
Revenues	0	0	67	285	440
Change in deficit	0	95	83	−25	−115

[1] Preliminary revenue estimates are from the Joint Committee on Taxation.

Note: Components may not sum to total due to rounding.

The effects of this bill fall within functions 570 and 550.

Basis of estimate: Under current law, the only outpatient prescription drugs that Medicare pays for are immunosuppressive drugs in the first year following a covered transplant operation. This section of the bill would expand Part B coverage to include all reasonable costs for prescription drugs above a deductible amount, which would be set at $800 for calendar year 1990 and indexed to the costs of drugs thereafter as determined by the Secretary. The deductible amount for the drug benefit would not count toward the

SMI copayment cap. About 9.2 percent of SMI enrollees would benefit from this provision in 1990, at an estimated benefit cost of $485 million for the fiscal year. Details on estimation of the benefit costs are discussed here.

There would be additional administrative costs as well, discussed in the section on amounts subject to appropriations.

Because the proposal involves a deductible amount, it is necessary to estimate not only total spending by Medicare enrollees on prescription drugs, but also how that spending is distributed among enrollees and what proportion of enrollees who would exceed the deductible amount would actually file claims for reimbursement. Each of these components is explained below.

Total spending on drugs by Medicare enrollees.—The CBO estimate of 1988 annual per capita prescriptions drug spending by Medicare enrollees of $250 was based on data from the Consumer Expenditure Survey (CES)—a 1984 survey of household spending from the Bureau of Labor Statistics. The CES shows that per person spending for prescription drugs in households headed by an elderly person was $137 in 1984. This figure was adjusted to reflect the age composition of households and direct purchases of drugs by third parties. This adjusted estimate of spending per elderly person was projected to average $288 in 1990 and $331 in 1992, based on published forecasts of drug expenditures from the Health Care Financing Administration.

Distribution of spending.—CBO estimates that 3.1 million Medicare beneficiaries—9.2 percent—would exceed a deductible of $800 on prescription drugs in 1990. This estimate is based on data from the 1977 Current Medicare Survey (CMS), a survey of about 5,000 Medicare beneficiaries. (The 1984 CES household level expenditure data cannot be used to provide an estimate of how expenditures vary by person.) In order to estimate the 1990 distribution of drug spending, the CMS data were increased proportionately to reflect a mean of $288.

Utilization and spending changes in response to the new benefit.—The estimates assume that use of prescription drugs would rise only slightly under the proposal. The small magnitude of this assumed response is based on two factors: (1) the large deductible and (2) the fact that drug utilization is primarily determined by physicians. Under the proposal only about 9 percent of enrollees would receive Medicare drug benefits. We assume that this deductible level would inhibit the increased use that might occur if, instead, drugs were provided at a lower deductible to a larger proportion of enrollees. Much of the potential induced demand for drugs under insurance is already reflected in baseline spending, because outpatient drugs are prescribed during physician visits. Since Medicare enrollees are already well insured for physicians' service under Medicare, Medicaid, and medigap policies, the addition of the proposed drug coverage would be expected to have little effect on prescription drug use.

Because several studies have estimated that up to 4 percent of all drugs that are dispensed to the elderly are provided free, this estimate assumes that many of these drugs no longer would be provided free to enrollees once Medicare reimbursement was available. A

spending increase of 2 percent was included in the estimate to reflect payment for previously free prescriptions by Medicare.

Participation rate.—The bill requires that enrollees and/or pharmacists initiate the request for reimbursement once the deductible has been exceeded. Those who use more than one pharmacist or who shop at nonparticipating pharmacies would have to request that the pharmacists add their prescription costs and forward them to the government. For a variety of reasons, some enrollees will not make this request and some pharmacies will not report all drug expenditures. For example, persons who are covered by employer-based insurance or who exceed the deductible by small amounts would have little motivation to apply for reimbursement. Hence, we assume that only 93 percent of eligible costs will actually be reimbursed.

Reimbursement limits.—The bill would reimburse drugs at the lower of three limits: the actual charge, the average wholesale costs plus a $4.50 dispensing fee, or 125 percent of the cost of the lowest available generic drug plus a $4.50 dispensing fee.

The effect of several of these limits on reimbursement is clear. The requirement for setting reimbursement at the lowest available generic drug price would reduce reimbursement. The estimated effect of the generic limit was based on data from the Food and Drug Administration, discussions with representatives of the Pharmaceutical Manufacturers Association and a variety of other experts. Based on these data and discussions, it appears that approximately one-half of all drugs sold have a generic equivalent, average markup of drugs by pharmacies appears to be approximately 40 percent, and the market share represented by generic drugs is increasing at a rapid rate. This bill would leave state policies unchanged with respect to the conditions under which a pharmacist could substitute generic drugs for name brand drugs. Given these factors, we estimate savings from the generic limit of 2.5 percent per year.

Increasing the Part B premium to cover resulting outlay costs.—This bill would require 75 percent of the expected increase in outlays for the drug benefit to be funded by an increase in the Part B premium. Currently, Part B premiums are based on incurred reimbursement costs per aged Medicare enrollee and pay only about 25 percent of those costs. Outlay estimates were obtained by adjusting incurred expenditures to allow for lags in payment, which are due to claims processing time and the delay in claim submissions. The monthly premium increase required by the drug benefit would be an estimated $1.40 in 1990, $2.60 in 1991, and $2.90 in 1992.

Federal Medicaid Savings.—About 9 percent of Medicare enrollees are also eligible for Medicaid benefits. For these enrollees, Medicaid generally pays both their medical costs not covered under Medicare and their SMI premium costs. Consequently, Medicaid costs would be reduced by this bill because of lower Medicaid drug costs for Medicare enrollees, partially offset by increased Medicaid costs for the higher SMI premiums.

Amounts Subject to Appropriations.—Administrative costs for the drug benefit would be composed of startup costs, fixed ongoing costs, and claims processing costs. These would total $95 million for fiscal year 1989, growing to $110 million by 1992.

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The costs for 1989 are entirely startup costs, necessary to finance the costs of hiring and training personnel, development and installation of computer hardware and software, and activities necessary to enroll pharmacists. Fixed ongoing costs would be used to increase central and regional Health Care Financing Administration office staff, to establish and maintain a nationwide data base of drug costs for enrollees, and to undertake utilization control and quality monitoring activities. Costs for claims processing would vary based on the number of claims that were processed, and on whether the claims were electronically submitted. In 1990, the estimated processing costs per claim are $1.20, and the estimate assumes that 25 million claims (for 38 million prescriptions) would be processed.

6. Estimated cost to state and local government: This bill would have an effect on state and local government budgets, because of changes that would accrue to state Medicaid programs from the new Medicare benefits. The effect is shown below.

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Effects on State/local Medicaid costs	0	0	−15	−35	−50

7. Estimate comparison: None.

8. Previous CBO estimate. Over the past several months, the CBO has made a number of estimates of proposals that would have Medicare insure some prescription drug spending by its enrollees, including H.R. 2470 as amended by the Committee on Energy and Commerce on June 17, 1987. In response to comments from the Administration and others, our data bases and estimating procedures have been improved. In particular, the data on which we base the mean and distribution of current law prescription drug spending have been changed, with two implications—the current methods result in what we believe to be better estimates and earlier estimates have been changed to reflect these improvements.

9. Estimate prepared by: Don Muse, Holly Harvey, Sandra Christensen, and Jack Rodgers.

10. Estimate approved by: C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

IV. Other Matters Required To Be Discussed

A. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means on the motion to report the committee amendment: the committee amendment was approved by a recorded vote of 24 to 12.

B. OVERSIGHT FINDINGS

In compliance with clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the committee reports that the need for

this legislation was confirmed by the oversight hearings of the Subcommittee on Health.

The subcommittee contributed part of a hearing conducted on the issue of catastrophic illness expenses on March 30, 1987, to the need for catastrophic prescription drug coverage under the Medicare program. A full hearing was devoted to prescription drug coverage on April 23, 1987, and June 2, 1987.

C. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, the committee states that no oversight findings and recommendations have been submitted to the Committee on Government Operations with respect to the subject matter contained in this amendment.

D. INFLATION IMPACT

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, with regard to the inflationary impact of the reported amendment, the committee believes that the amendment has no measurable effect on health care prices generally as the amendment is budget neutral in each of the 5 years for which cost estimates are available.

V. Statutory Language of Committee Amendment

AMENDMENTS TO H.R. 2470

(Relating to Coverage of Outpatient Prescription Drugs Under Medicare) As Reported by the Committee on Ways and Means

[Page and line numbers refer to H.R. 2470, As Introduced]

Page 21, line 5, strike "medicare inflation factor" and insert "the sum of the medicare inflation factor and the prescription drug factor."

Page 21, after line 17, insert the following new subparagraph:

"(D) PRESCRIPTION DRUG FACTOR.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the prescription drug factor—

"(I) for 1988 and 1989 is 0 percent;

"(II) for 1990, is 3.5 percent; and

"(III) for a subsequent year, is the percent determined under clause (ii) for that year.

"(ii) DETERMINATIONS.—In September of each year (beginning with 1990) the Secretary shall establish a prescription drug factor for purposes of subparagraph (B) for taxable years beginning in the succeeding calendar year. Subject to clause (iii), the prescription drug factor with respect to taxable years beginning in a calendar year shall be the percent the Secretary estimates to be necessary so that the total amount of additional premiums which the Secretary estimates is collectible under this section for such taxable years by virtue of the establishment of such factor is equal to 25 percent of the total amount determined by the Sec-

retary of Health and Human Services under section 1839(g)(1)(B)(i) that will be paid in the calendar year.

"(iii) DETERMINATION OF SURPLUS OR DEFICIT.—In September of each year (beginning with 1992) the Secretary shall determine—

"(I) the total amount of additional premiums which were collectible under this section with respect to taxable years beginning in calendar years after 1989 and before the previous calendar year by virtue of the prescription drug factor for that year, and

"(II) whether the amount described in subclause (I) is greater or less than 25 percent of the sum of the totals determined by the Secretary of Health and Human Services under section 1839(g)(1)(C)(i)(II) for calendar years after 1989 and before the previous calendar year.

"(iv) ADJUSTMENT.—If the Secretary determines under clause (iii)(II) in a year that there is as a surplus or deficit described in that clause, the Secretary shall adjust the prescription drug factor otherwise determined under this subparagraph for taxable years beginning in the succeeding year so as to reduce or increase, respectively, the aggregate amount of the additional premiums which are estimated to be collectible under this section for taxable years beginning in that succeeding year (or, in the Secretary's discretion, for taxable years beginning in the 2-year period beginning with that succeeding year) by the amount of such surplus or deficit. In making such adjustment, the Secretary shall take into account the effect of previous adjustments made under this clause.

Page 21, line 18, strike "(D)" and insert "(E)".

Page 24, line 6, strike "and (f)" and insert "(f), and (g)".

Page 30, after line 16, insert the following new section (and redesignate the succeeding sections, and conform the table of contents, accordingly):

SEC. 202. COVERAGE OF CATASTROPHIC EXPENSES FOR PRESCRIPTION DRUGS AND INSULIN.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by amending subparagraph (J) of subsection (s)(2) to read as follows:

"(J)(i) drugs described in subsection (t)(2)(A) used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant, and (ii) covered outpatient drugs (as defined in subsection (t)(2)); and", and

(2) in subsection (t)—

(A) by striking "subsection (m)(5)" and inserting "subsections (m)(5) and (s)(2)(J)(ii) and paragraph (2)",

(B) by inserting "(1)" after "(t)", and

(C) by adding at the end the following new paragraph:

"(2) The term 'covered outpatient drug' means—

"(A) a drug which—

"(i) is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act, or

"(ii) in the case of a drug which is biological product, is licensed under section 351 of the Public Health Service Act, and

"(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act;

but does not include any drug or insulin provided to an inpatient as part of inpatient hospital services (described in subsection (b)(2)), as part of extended care services (described in subsection (h)(5)), or as an incident to physicians' services under subparagraph (A) or (B) of subsection (s)(2), and does not include drugs under the conditions described in subsection (s)(2)(J)(i).".

(b) DEDUCTIBLE AND PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1833 (42 U.S.C. 13951(b)) is amended—

(A) in subsection (a)(1)—

(i) by striking "and" before "(H)", and

(ii) by adding at the end the following:

"(I) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under subsection (m)(2), and (J) with respect to drugs under the conditions described in section 1861(s)(2)(J)(i), the amounts paid shall be the amounts determined under subsection (m)(2) (without regard to the deductible established under subsection (m)(1)(A) but taking into account the deductible established under subsection (b))";

(B) in subsection (b)—

(i) in clause (1), by inserting "or for covered outpatient drugs" after "1861(s)(10)(A)", and

(ii) in clause (2), by inserting "or with respect to covered outpatient drugs" after "home health services"; and

(C) by adding at the end the following new subsection:

"(m) PAYMENT FOR COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) IN GENERAL.—Before applying paragraph (2) with respect to expenses incurred by an individual for covered outpatient drugs dispensed in a calendar year, the individual must establish that the individual has incurred (or has had paid on the individual's behalf) expenses for covered outpatient drugs dispensed in the year (during a period in which the individual is entitled to benefits under this part) of the amount specified in subparagraph (C) for that year.

"(B) RESPONSE TO APPLICATION.—If an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the

pharmacy) as to whether or not the individual has met such requirement.

"(C) DEDUCTIBLE AMOUNT.—

"(i) IN GENERAL.—The amount specified in this subparagraph for—

"(I) 1990 is $800; and

"(II) each subsequent year, is the amount specified in this subparagraph for the previous year increased by the percentage change in the index determined under clause (ii) in September of the previous year.

"(ii) COVERED OUTPATIENT DRUG INDEX.—The Secretary shall establish by regulation an index which reflects the prices of covered outpatient drugs. The Secretary shall use, as a base point, the prices for the drugs as of August 1989. In September before each year (beginning with 1991) the Secretary shall determine the percentage change in the index during the 12-month period ending with the previous month.

"(iii) ROUNDING.—Any amount determined under this subparagraph which is not a multiple of $1 shall be rounded to the next highest multiple of $1.

"(iv) PUBLICATION.—In September of each year (beginning with 1990) the Secretary shall publish the deductible established under this subparagraph for the following year.

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the deductible established under paragraph (1)(A) (or, with respect to drugs described in section 1861(s)(2)(J)(i), the deductible established under subsection (b)), the amounts payable under this part with respect to a covered outpatient drug or a drug described in section 1861(s)(2)(J)(i) is equal to—

"(i) the lesser of—

"(I) the actual charge for the drug, or

"(II) the applicable payment limit described in paragraph (3) or paragraph (4); minus

"(i) 20 percent of the actual charge for the drug.

"(B) PUBLICATION OF PAYMENT LIMITS.—The Secretary, before each payment calculation period (as defined in paragraph (9)(C)) beginning on or after January 1, 1990, shall provide for the distribution to participating pharmacies (as defined in section 1842(i)) and to groups representing or assisting individuals entitled to benefits under this part, of information on the payment limits established under paragraphs (3) and (4).

"(C) TREATMENT OF CERTAIN PREPAID ORGANIZATIONS.—In applying subparagraph (A) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

"(i) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in

payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract or with respect to individuals furnished covered outpatient drugs through the organization or a facility if payments were to be made on an individual-by-individual basis, and

"(ii) the organization shall provide assurances satisfactory to the Secretary that the organization or such a facility will not undertake to charge an individual more than 20 percent of such reasonable cost plus any amounts payable by the individual as a result of paragraph (1).

"(3) PAYMENT LIMIT FOR NON-MULTIPLE SOURCE DRUGS AND DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—

"(A) IN GENERAL.—In the case of a drug that either is not a multiple source drug (as defined in paragraph (9)(A)) or is a multiple source drug and has a restrictive prescription (as defined in paragraph (9)(B)), the payment limit for the drug under this subsection is the sum of—

"(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the average per tabled or unit wholesale price for the drug (as determined under subparagraph (B)), and

"(ii) an administrative allowance in the amount determined under paragraph (5).

"(B) DETERMINATION OF UNIT PRICE.—For purposes of this paragraph, the Secretary shall determine, with respect to dispensing of a covered outpatient drug in a payment calculation period (beginning on or after January 1, 1990), the average per tablet or unit wholesale price for the drug. Such average shall be based on the average wholesale price for purchases in reasonable quantities. Such determination shall be made for each payment calculation period based on wholesale prices for the first day of the third month before the beginning of the period. The Secretary shall make such determination, and calculate the payment limits under subparagraph (A), on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale price for a drug product.

"(4) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—

"(A) IN GENERAL.—In the case of a drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph is the sum of—

"(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the amount specified under subparagraph (B)(i), and

"(ii) an administrative allowance in the amount determined under paragraph (5).

"(B) UNIT LIMIT.—

"(i) IN GENERAL.—The amount specified under this clause with respect to a multiple source drug dispensed in a payment calculation period is 50 percent of the brand name reference price (established under clause (ii)) for the reference drug product (as defined in clause (iv)) for the period.

"(ii) BRAND NAME REFERENCE PRICE.—The Secretary shall establish, for purposes of clause (i), a brand name reference price for each reference drug product for each payment calculation period. The brand name reference price with respect to a reference drug product—

"(I) for the 6-month period beginning with January 1987, is the average per tablet or unit wholesale price (based on purchases in reasonable quantities) for the reference drug product as of January 1, 1987, or

"(II) for a subsequent payment calculation period, is the brand name reference price established for the previous period increased by the percentage increase in the consumer price index for all urban consumers (all items, U.S. city average, as published by the Bureau of Labor Statistics) for the 6-month period ending in the third month of the previous period.

In the case of a reference drug product which is not available as of January 1, 1987, but which is first available in a payment calculation period after such date, the Secretary shall establish the brand name reference price as the average per tablet or unit wholesale price for the reference drug product (based on purchases in reasonable quantities) in the first month of the first payment calculation period in which it is available.

"(iii) BASIS.—The Secretary shall establish brand name reference prices under clause (ii) on a national basis; except that the Secretary may establish such prices on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale price for a drug product.

"(iv) REFERENCE DRUG PRODUCT DEFINED.—In this subparagraph, the term 'reference drug product' means, with respect to a multiple source drug, the drug product described in paragraph (9) (A) with reference to which other drug products are rated as therapeutically equivalent in the publication described in such paragraph.

"(5) COMPUTATION OF ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMITS.—

"(A) FOR 1990.—For drugs dispensed in a payment calculation period beginning in 1990, the administrative allowance under this paragraph is $4.50.

"(B) FOR LATER YEARS.—

"(i) IN GENERAL.—For drugs dispensed in a subsequent payment calculation period, the administrative allowance under this paragraph is the administrative allowance under this paragraph for the preceding calculation period increased by the percentage increase (if any) in the index established under clause (ii). Any allowance determined under the preceding sentence which is not a multiple of 1 cent shall be rounded to the nearest multiple of 1 cent.

"(ii) PHARMACY INDEX.—The Secretary shall establish by regulation an index which reflects the costs of pharmacies dispensing covered outpatient drugs, taking into account changes in productivity. The Secretary shall use, as a base point, the costs of furnishing the drugs as of August 1989. In September before each year (beginning with 1991) the Secretary shall determine the value of the index for the previous month and the percentage change in the index between August 1989 and the previous month.

"(6) ASSURING APPROPRIATE UTILIZATION.—The Secretary shall establish a utilization review program for covered outpatient drugs to identify instances of unnecessary or inappropriate prescribing or dispensing practices and to identify quality of care problems.

"(7) TREATMENT OF CERTAIN PREPAID ORGANIZATIONS.—In the case of covered outpatient drugs furnished by an eligible organization (described in section 1876(b)) or an organization described in section 1833(a)(1)(A) which does not impose charges on covered outpatient drugs dispensed to its members—

"(A) for purposes of this subsection the actual charges of the organization shall be the organization's standard charges to members and other individuals not entitled to benefits with respect to such drugs, and

"(B) for purposes of meeting the deductible established under paragraph (1), there shall be taken into account the standard charges that are fully or partially prepaid for covered outpatient drugs.

"(8) PHYSICIAN GUIDE.—

"(A) IN GENERAL.—The Secretary shall develop, and update annually, an information guide for physicians concerning the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient drugs. Such guide shall, to the extent practicable, group covered outpatient drugs (including multiple source drugs) in a manner useful to physicians by therapeutic category or with respect to the conditions for which they are prescribed. Such guide shall specify the wholesale prices on the basis of the amount of the drug required for a typical daily therapeutic regimen.

"(B) MAILING GUIDE.—The Secretary shall provide for mailing, not later than March 1 of each year (beginning with 1990), a copy of the guide developed and updated under subparagraph (A)—

"(i) to each hospital with an agreement in effect under section 1866, and

"(ii) to each physician (as defined in section 1861(r)(1)) who routinely provides services under this part.

"(9) DEFINITIONS.—In this subsection:

"(A) MULTIPLE SOURCE DRUG.—The term 'multiple source drug' means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

"(i) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations,' available on the first day of the third month before the beginning of the period), and

"(ii) are sold or marketed during the period.

For purposes of clause (ii), a drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i) for the third month before the beginning of the period, unless the Secretary determines that such sale or marketing is not actually taking place.

"(B) RESTRICTIVE PRESCRIPTION.—A drug has a 'restrictive prescription' only if the prescription for the drug indicates, in accordance with the applicable law of the State in which the prescription was written, that the particular drug must be dispensed.

"(C) PAYMENT CALCULATION PERIOD.—The term 'payment calculation period' means the 6-month period beginning with January of each year and the 6-month period beginning with July of each year."

(2) REPORT ON PAYMENT LIMITS.—The Secretary of Health and Human Services shall review the payments limits described in paragraphs (3) and (4) of section 1833(m) of the Social Security Act on covered outpatient drugs and shall report to Congress, by not later than April 1, 1989, on the appropriateness of such limits. The Secretary shall include in such report such recommendations for changes in such limits as may be appropriate.

(c) PARTICIPATING PHARMACIES.—Section 1842 (42 U.S.C. 1395t) is amended—

(1) in subclauses (III) and (IV) of subsection (c)(2)(B)(ii), by inserting "or by participating pharmacies" after "participating physicians" each place it appears;

(2) in subsection (h)(1), by inserting before the period at the end of the second sentence the following: "and, with respect to a supplier of covered outpatient drug, is a participating pharmacy (as defined in subsection (i)(1))"; and

(3) by adding after subsection (h) the following new subsection:

"(i)(1) For purposes of this section, the term 'participating pharmacy' means an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

"(A) The entity agrees—

"(i) not to refuse to dispense covered outpatient drug items stocked by the entity to any individual entitled to benefits under this part (in this section referred to as 'medicare beneficiaries'), and

"(ii) not to charge medicare beneficiaries more for such drugs than the amount it charges to the general public.

"(B) The entity agrees to keep patient records (including records on expenses incurred by medicare beneficiaries) for all covered outpatient drugs dispensed to all such beneficiaries.

"(C) The enity agrees—

"(i) to assist medicare beneficiaries in determining whether or not their expenses (for covered outpatient drugs dispensed in a year) have exceeded the deductible under section 1833(m)(1)(A), including providing the documentation necessary to establish this, and

"(ii) on behalf and on the request of such a beneficiary, to submit to the carrier such documentation as the Secretary requires.

"(D) The entity agrees, upon request of a medicare beneficiary, to provide a copy of the records maintained under subparagraph (B) to another participating pharmacy or to a carrier under this section.

"(E) The entity agrees—

"(i) to offer to counsel, or to offer to provide information to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

"(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

"(F) Effective January 1, 1992, the entity agrees to submit all requests for payment under this part to carriers electronically; except that this subparagraph shall not apply to an entity located in a rural area (as defined in section 1886(d)(2)(D)).

Nothing in this paragraph shall be construed as requiring a pharmacy operated by an eligible organization (described in section 1876(b)) or an organization described in section 1833(a)(1)(A) for the exclusive benefit of its members to dispense covered outpatient drugs to individuals who are not members of the organization.

"(2) The Secretary shall provide to each participating pharmacy—

"(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

"(B) before the beginning of each payment calculation period, information on the payment limits established under paragraphs (3), (4), and (5) of section 1833(m).

"(3) The Secretary shall provide for periodic audits of participating pharmacies to assure that they do not impose charges in excess of the amounts permitted under paragraph (1)(A)(ii).

"(4) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment de-

scribed in clause (ii) of that subsection only to a participating pharmacy.".

(d) LIMITATION TO 60-DAY PRESCRIPTION.—Section 1862(c) (42 U.S.C. 1395y(c)) is amended—

(1) by redesignating subparagraphs (A) through (D) of paragraph (1) as clauses (i) through (iv), respectively;

(2) in paragraph (2)(A), by striking "paragraph (1)" and inserting "subparagraph (A)";

(3) by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively;

(4) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(5) by inserting "(1)" after "(c)"; and

(6) by adding at the end the following new paragraph:

"(2) No payment may be made under part B for any expense incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a 60-day supply.".

(e) ADDITIONAL PREMIUM FOR PRESCRIPTION DRUG BENEFIT.—For amendments providing for additional premiums to pay for the additional benefits provided under the amendments made by this section, see sections 106(a) and 206(d) of this Act.

(f) USE OF CARRIERS IN ADMINISTRATION.—

(1) ADDITIONAL FUNCTIONS OF CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (H),

(B) by adding "and" at the end of subparagraph (I), and

(C) by inserting after subparagraph (I) the following new subparagraph:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) offer to receive requests for payments for such drugs through electronic communications, and

"(ii) respond to requests by participating pharmacies as to whether or not an individual has met the deductible requirement of section 1833(m)(1)(A) for a year;".

(2) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) is amended by adding at the end the following new sentence: "With respect to carrying out functions relating to payment for covered outpatient prescription drugs the Secretary may enter into contracts with carriers under this section to perform such functions on a regional basis.".

(g) MODIFICATION OF HMO/CMP RISK-SHARING CONTRACTS.—

(1) COUNTING OF EXPENSES BEFORE ENROLLMENT.—Section 1876(c) (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

"(8) In the case of an individual who enrolls as a member of an eligible organization under this section after January 1 of a year, the organization must take into account, in computing the expenses incurred for covered outpatient drugs for purposes of meeting the deductible under section 1833(m)(1)(A) for the year, expenses incurred for covered outpatient drugs during the year while the individual was entitled to benefits under part B but before the individual so enrolled.".

(2) ADJUSTMENT OF AAPCC AND CONTRACTS.—The Secretary of Health and Human Services shall—

(A) take into account the amendments made by this section in estimating the adjusted average per capita cost under section 1876(a) of the Social Security Act for eligible organizations with risk sharing contracts under that section for portions of contract years occurring after December 31, 1989;

(B) modify such contracts, for such portions of contract years, to reflect any adjustments made under paragraph (1); and

(C) require such organizations to make appropriate adjustments (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account the amendments made by this section.

(h) CONFORMING AMENDMENTS.—

(1) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) by inserting "1833(m)," after "1833(b),"; and

(B) by inserting "and in the case of covered outpatient drugs, 20 percent of the actual charges for the drugs" after "established by the Secretary".

(2) Section 1903(i)(5) (42 U.S.C. 1396b(i)(5)) is amended by striking "section 1862(c)" and inserting "section 1862(c)(1)".

(i) REPORT ON EXPENDITURES.—The Secretary of Health and Human Services shall report to the Congress, by May 1, 1992, concerning expenditures in 1991 under part B of title XVIII of the Social Security Act for covered outpatient drugs. If the Secretary reports that such expenditures have exceeded $2,220,000,000, the Secretary shall include in the report a recommendation for changes in policies (including an increase in the deductible applicable to covered outpatient drugs for 1993) sufficient to reduce expenditures under such part for such drugs for 1993 by the amount of such excess (increased by the estimated percentage increase in such expenditures per enrollee during the 2-year period ending in 1992).

(j) BENEFICIARY DRUG COST SURVEY AND CBO REPORT.—

(1) SURVEY.—(A) The Secretary of Health and Human Services shall conduct a statistically valid survey of expenses for covered outpatient drugs (as defined in section 1861(t)(2) of the Social Security Act) incurred by medicare beneficiaries.

(B) In developing the design of the survey, the Secretary shall consult with the Comptroller General and the Director of the Congressional Budget Office.

(C) The survey shall be designed so as to provide information on the distribution of expenses for covered outpatient drugs for medicare beneficiaries generally and, within the population of such beneficiaries, the distribution of such expenses by age, sex, income, and institutionalized status.

(D) The Secretary shall submit to Congress, by not later than March 1, 1989, a report on the survey conducted under this paragraph.

(2) REESTIMATION OF COSTS.—The Director of the Congressional Budget Office shall transmit to the Congress, not later than 2 months after the date the report is made under paragraph (1), the Director's estimate of the expenditures which will be made (in each of fiscal years 1990, 1991, 1992, and 1993) under the medicare program for covered outpatient drugs (under the amendments made by this section).

(k) PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION.—Part B is amended by adding at the end the following new section:

"PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

"SEC. 1846. (a)(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than October 1, 1989, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

"(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one individual who is a medicare beneficiary.

"(b) The Commission shall make recommendations to the Congress not later than March 1 of each year concerning methods for payment for covered outpatient drugs under this part.

"(c) Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.".

(l) ADDITIONAL STUDIES.—The Secretary of Health and Human Services shall conduct studies on the following issues:

(1) The extent of private or other third-party insurance coverage of covered outpatient drugs among medicare beneficiaries.

(2) A comparison of published average wholesale prices and actual pharmacy acquisition costs by type of pharmacy.

(3) The overhead costs of retail pharmacies.

(4) Potential application of new claims processing and billing technologies to payment for covered outpatient drugs.

(5) Methods for review of utilization of covered outpatient drugs.

(6) Alternative payment methodologies for covered outpatient drugs that promote greater program efficiency, including use of lower cost medications.

(7) The potential for induced demand resulting from the coverage of covered outpatient drugs under the medicare program.

As part of such studies the Secretary shall conduct a longitudinal study on the use of covered outpatient drugs by medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage. The Secretary shall report to Congress on the results of such studies over a period ending not later than January 1, 1991.

(m) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to covered outpatient drugs dispensed on or after January 1, 1990.

(2) CARRIERS.—The amendments made by subsections (f) and (k) shall take effect on the date of the enactment of this Act.

(3) HMO/CMP ENROLLMENTS.—The amendment made by subsection (g)(1) shall apply to enrollments effected on or after January 1, 1990.

Page 35, at the end of line 16, add the following: "but subject to the provisions of subsection (g),".

Page 36, at the end of line 8, add the following: "but subject to the provisions of subsection (g),".

Page 37, line 2, insert "(other than section 202 thereof)" after "1987".

Page 38, at the end of line 18, add the following: "but subject to the provisions of subsection (g),".

Page 39, line 9, insert "(other than section 202 thereof)" after "1987".

Page 40, after line 12, insert the following new subsection:

(d) ADDITIONAL PREMIUM FOR PRESCRIPTION DRUG BENEFIT.—Section 1839 (42 U.S.C. 1395r) is amended—

(1) in the second sentence of subsection (a)(1), by inserting "(other than costs relating to covered outpatient drugs)" before the period;

(2) in subsection (a)(2), by striking "and (e)" and inserting ", (e), and (g)";

(3) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";

(4) in the second sentence of subsection (a)(4), by inserting "(other than costs relating to covered outpatient drugs)" before the period; and

(5) by adding at the end of the following new subsection:

"(g) ADDITIONAL PREMIUM FOR PRESCRIPTION DRUG BENEFIT.—

"(1) DETERMINATION OF ACTUARIAL RATE.—

"(A) FOR 1990.—For purposes of this subsection, the monthly actuarial rate determined according to this paragraph for 1990 is $1.40.

"(B) FOR SUBSEQUENT YEARS.—In September of each year (beginning with 1990) the Secretary shall determine—

"(i) the total of the benefits and administrative costs which he estimates will be paid from the Federal Sup-

plementary Medical Insurance Trust Fund in such succeeding calendar year for covered outpatient drugs and related administrative costs, and

"(ii) a monthly actuarial rate for covered outpatient drugs which shall be applicable for the succeeding calendar year, which rate shall be the rate the Secretary estimates to be necessary so that the aggregate amount of the increase in premiums collected or received under paragraph (3) for such year will equal 75 percent of the total determined under clause (i) for that year.

"(C) ADJUSTMENT FOR PREVIOUS SURPLUSES OR DEFICITS.—

"(i) DETERMINATION AS TO WHETHER TO MAKE AN ADJUSTMENT.—In September of each year (beginning with 1991), the Secretary shall determine—

"(I) the aggregate amount of the monthly premium increases collected or received under paragraph (3) during the previous year;

"(II) the total of the benefits and administrative costs which the Secretary determines were paid in the previous year from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs; and

"(III) whether the amount described in subclause (I) is greater or less than 75 percent of the total described in subclause (II).

"(ii) ADJUSTMENT TO MONTHLY ACTUARIAL RATE.—If the Secretary determines under clause (i)(III) in a year that there was a surplus or deficit described in that clause in the previous year, the Secretary shall adjust the monthly actuarial rate otherwise determined under subparagraph (B)(ii) for the succeeding year so as to reduce or increase, respectively, the aggregate amount of the monthly premium increases that otherwise would be collected or received under paragraph (3) during such period by the amount of such surplus or deficit, respectively.

"(D) DETERMINATION OF POTENTIAL PREMIUM REVENUES BASED ON MONTHLY ACTUARIAL RATE.—In September of each year (beginning with 1990) the Secretary shall determine, for purposes of section 59B(b)(4)(D)(ii) of the Internal Revenue Code of 1986, the total of the monthly premium increases which the Secretary estimates would be collected or received in the succeeding year under paragraph (2) if the monthly actuarial rate were not subject to any adjustment under paragraph (1)(C)(ii).

"(2) MONTHLY PREMIUM INCREASE APPLIED.—Notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1989 shall be increased by the following:

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the monthly actuarial rate established under paragraph (1) for that year.

"(B) RESIDENTS OF COMMONWEALTH AND TERRITORIES.—In the case of an individual who is a resident of a commonwealth or territory (as defined in subsection (e)(4)(E)(i)) during the month, the product of—

"(i) 133⅓ percent of the monthly actuarial rate established under paragraph (1) for that year, and

"(ii) the ratio determined by the Secretary for that commonwealth or territory under subsection (e)(4)(B)(ii).

"(C) PART B ONLY INDIVIDUALS.—In the case of a part B only individual (as defined in subsection (e)(5)(E)), 133⅓ percent of the monthly actuarial rate established under paragraph (1) for that year.

However, if an increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents."

Page 40, line 13, strike "(d) CONFORMING AMENDMENT.—" and insert "(e) CONFORMING AMENDMENTS.—(1)".

Page 40, after line 16, insert the following new paragraph:

(2) Section 1844(a) (42 U.S.C. 1395w(a)(1)) is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g).".

Page 40, line 17, strike "(e)" and insert "(f)".

Page 41, line 1, strike "(d)" and insert "(e)".

Page 41, after line 3, insert the following new paragraph:

"(4) The amendments made by subsection (e) shall apply to monthly premiums for months beginning with January 1990.".

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